



STATE OF TENNESSEE

**Health Link: Comprehensive Care
Management:
A Closer Look**

3/22/18

Maria Montanaro

Maria Montanaro is a Director within Navigant's Government Healthcare Solutions practice. She has provided executive leadership to health plans, primary care provider groups, integrated networks, and state departments of health and human services. Maria has planned state and organizational budgets, set strategy, led mergers, developed policies, implemented programs and participated in Medicaid reform initiatives in collaboration with state and governmental leaders, insurers, providers, consumers and advocates. Her expertise spans both the medical and behavioral health field. Throughout her career, she has worked closely with state and national legislatures, governmental agencies and local communities. Maria is regarded as a trusted leader and expert in the field of community based primary care and public health.



Learning Objectives

At the end of this webinar you will:

1. Have an understanding of the Health Link service, Comprehensive Care Management
2. Understand how to use Population Management for improving health outcomes for Health Link members
3. Be able to develop an Integrated Care Plan for Health Link members

Introduction and Overview of Series

Health Link Services Deep-Dive:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Transitional Care
5. Member and Family Support
6. Referral to Social Supports

What is Comprehensive Care Management?

Comprehensive Care Management

- As defined in the Tennessee Health Link Provider Operating Manual:*
Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan as needed.
 - Example: creating care coordination and treatment plans

Code	Activity	Member or Collateral	Face-to-face or Indirect
G9004	Comprehensive care management: <i>Initiate, complete, update, or monitor the progress of a comprehensive person-centered care plan</i>	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect

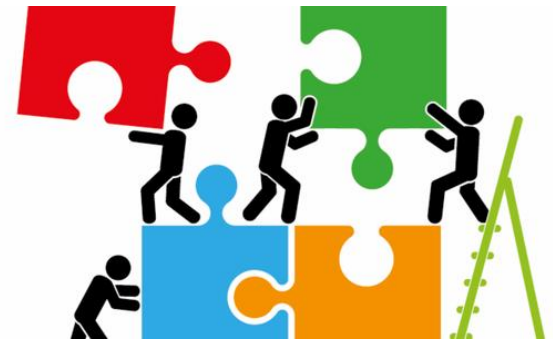
Four Components of Comprehensive Care Management

The Comprehensive Person-Centered Care Plan

1. Initiate: Identifying members
 - a. Gathering member information using EHR and CCT and member reports
2. Complete: Assemble the information, developing the plan
 - a. Educate members or parent/guardians about their conditions and how to manage them
 - b. Assess members' or parent/guardians' perceived barriers to treatment
3. Update:
 - a. Regular reassessments for capturing new information or changes
 - b. Include information from other providers
4. Monitor members' participation in and response to treatment
 - a. Regular brief check-ins (by phone or in person) to assess progress

Comprehensive Care Management: Managing the Health Link Population

- Managing the Health Link population can be achieved through adopting a population management approach to care
- The tools you will need include:
 - Health Link Members
 - CCT
 - EHR
 - Care Manager
 - Health Link Team
 - Treatment Team (including both internal and external providers)




Population Management

What is Population Management?

- Population-based care focuses on the health of an entire patient population by systematically **assessing, tracking, and managing** the group's health conditions and treatment response across the entire target group, *rather than just responding to the patients who actively seek care.*

Key Principles for Population Management


Population-Based Care: Focus on caring for the whole population you are serving, not just the individuals actively seeking care



Data-Driven Care: Utilize data and analytics in order to make informed decisions to serve those in your population who most need care



Evidence-Based Care: Make use of the best available evidence to guide treatment decisions and delivery of care



Care Management: Engage in actionable care management for the population you serve

1. Population-Based Care

- One of the key changes an agency must make to become a health home is transitioning from care that is driven by a series of individual patients' current chief complaints to care that is driven by analyzing the whole population or subpopulations served for care gaps, and then using data analytics to select a group of patients with the most urgent care needs for the greatest opportunities for care improvement.
- Using the CCT and EHR to track the patient care data over time and can select for a particular condition, set of characteristics, practice/provider group, or other parameter.
- Providers need staff assigned to actively and systematically assess, track, and manage the group's health conditions and treatment responses.

Develop capacity to gather and aggregate data to use in three ways:

1. Develop a comprehensive picture of overall care received and current care gaps for each individual patient/client.
2. Sort out which individual patient/client should receive immediate attention that day/week out of their total health home population.
3. Track improvement in both process and clinical outcome performance indicators, both internally and in comparison to other health problems.

One of the greatest flaws of current care delivery:
Depending on the patient's ability alone to know when they need care and what care to ask for.

2. Data-Driven Care

- Data-driven care is essential for successful population management and makes the difference between success and failure for health homes with value-based contracts.
- Providers engaged in population management are continuously engaged in
 - collecting,
 - organizing,
 - sharing, and
 - applying objective, valid clinical data to guide treatment



Using Data-Driven Care

FIRST STEP: Gather the Data

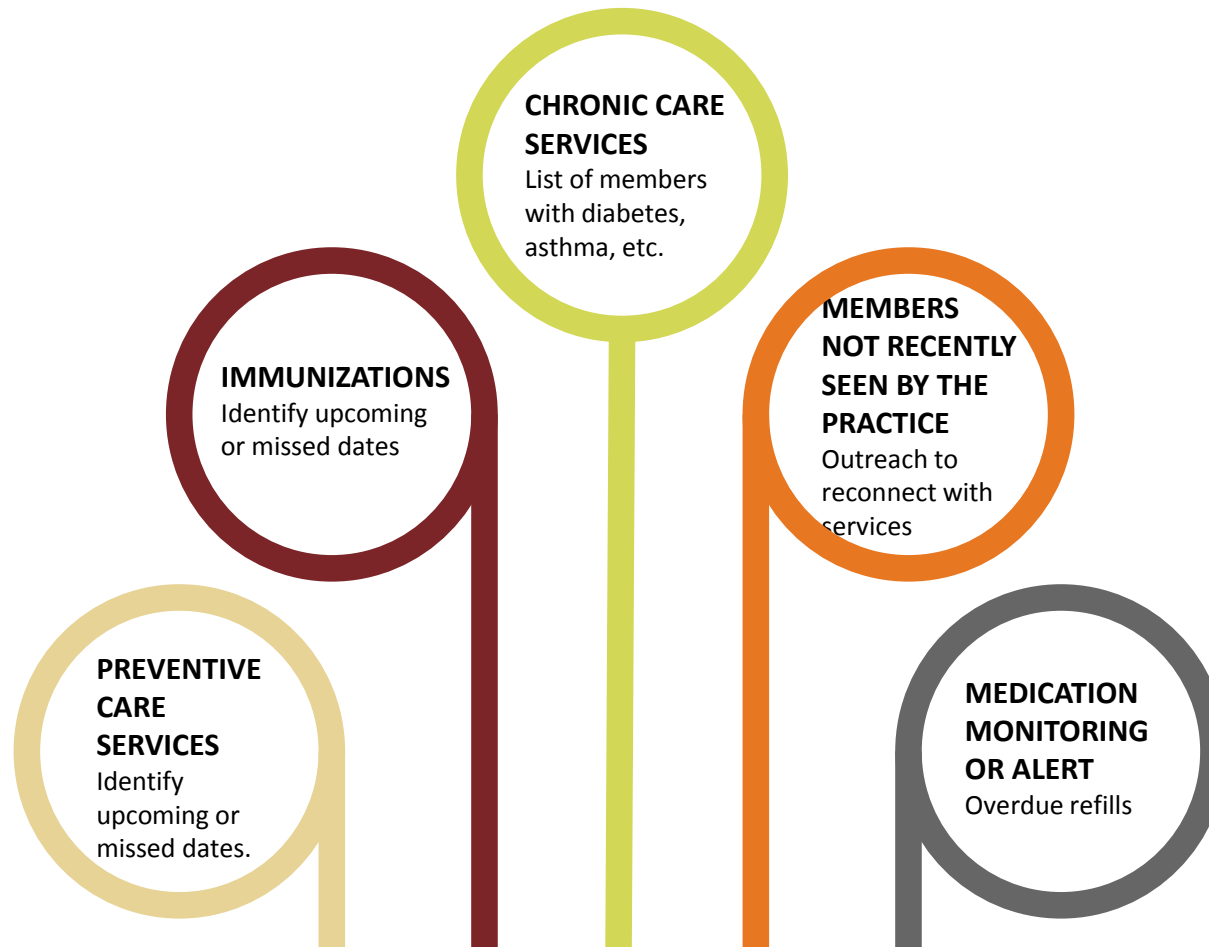
- Using the CCT and EHRs to develop data sets with individual demographic, health, and community status information and strategy for obtaining and integrating the available data sets for program planning and individual care management.
- There are two major sources of individual personal health information usually available for this initial analysis:
 1. Payer patient claims information from the CCT (Patient claims information has the advantage of providing a limited record of all care by all providers funded by that individual payer)
 2. EHR data extracts
- Claims provide a record of all medications, ER visits, hospital admissions, outpatient visits, and specialty services. They include dates of service, providers, diagnoses, billing codes, pharmacy details.

SECOND STEP: Using the Data

- Use the CCT to organize by **diagnosis, assessment, or lab results as well as subgroups** (e.g., members with schizophrenia and diabetes and recent hospitalizations) or individual patients with specific treatment needs (e.g., patients without a primary care visit in three or more years).
- Registries can identify subgroups of patients who are overdue for a follow-up appointment or necessary procedure.
- The data can be sorted by provider or by practice in larger systems, allowing organizations to evaluate performance and identify training needs.
- Some EHRs can be customized to provide a registry function or can be modified to allow for integration with the registry.

Analyzing the Population

Identifying common characteristics among members, such as:



Feedback from Coaches on Health Link Provider Successes

- ✓ Teams receive on-going training and in-services on physical health conditions and how they impact behavioral health
- ✓ Comprehensive assessment has been expanded to include physical health
- ✓ Comprehensive care plans have been expanded to be more integrated:
 - Primary care conditions
 - Preventive care needs
 - Family history
 - Self management goals
- ✓ Updated workflows to include physical health:
 - The clinic RN and directors are now utilizing different strategies to maintain an up-to date problem list and include medical recommendations from the primary care providers
 - Specific staff designated as the care manager- support and oversight has improved accountability for these functions/tasks
 - Staff is using the CCT daily to track ADTs and scheduling follow-up appointments in a timely manner
 - The treatment planning and assessments have always been done as a part of their intake process. However, the physical health integration just became a part of their care after becoming THL.
- ✓ Through collaboration with other providers who are involved in their patient's care, they are closing gaps in care
- ✓ Improved outcomes:
 - One Health Link organization reported improvement in BMI rates by 75% from baseline in January 2017
 - A1c rates have improved by 53%.

Using Data

- Using data for managing member care is a relatively new way of providing care for many behavioral health organizations
- It's easy to become overwhelmed with all the data
- Implementing effective ways of managing the data is needed



Health Link

Behavioral Health Quality Measure Ranges

Behavioral Health Quality Measures		Highest	Lowest	Benchmark
7- & 30-day psychiatric hospital/RFT readmission rate				
	7 day rate	0.0%	10.4%	<=5.0%
	30 day rate	0.0%	24.6%	<=15.0%
Antidepressant medication management				
	Effective acute phase treatment	72.7%	27.0%	>=55.0%
	Effective continuation phase treatment	49.0%	11.0%	>=40.0%
Follow-up after hospitalization for mental illness within 7 and 30 days				
	7 day rate	83.0%	15.4%	>=60.0%
	30 day rate	89.0%	34.1%	>=75.0%
Alcohol & drug (A&D) dependence treatment				
	Initiation of A&D dependence treatment	69.5%	36.0%	>=45.0%
	Engagement of A&D dependence treatment	29.3%	6.0%	>=15.0%
Use of multiple concurrent antipsychotics in children/adolescents		0.0%	16.7%	<=1.0%
Report Period: 01/01/2017 – 12/31/2017				

Health Link

Physical Health Quality Measure Ranges

Physical Health Quality Measures		Highest	Lowest	Benchmark
BMI and weight assessment				
Adult BMI screening rate		82.3%	39.4%	>=60.0%
BMI percentile (children)		75.0%	19.2%	>=30.0%
Comprehensive diabetes care (composite 1)				
Eye Exam		63.0%	16.7%	>=40.0%
BP < 140/90		45.8%	2.0%	>=50.0%
Nephropathy		96.3%	81.1%	>=85.0%
Comprehensive diabetes care (composite 2)				
HbA1c testing		88.0%	70.7%	>=85.0%
HbA1c poor control (>9%)		86.5%	49.0%	>=50.0%
EPSDT Well-child visits ages 7-11 years		100.0%	33.3%	>=55.0%
EPSDT Well-child visits ages 12-21 years		60.0%	32.8%	>=45.0%
Report Period: 01/01/2017 – 12/31/2017				

Health Link Efficiency Measures (per 1,000 Member Months)

Efficiency Measure	Highest	Lowest	Benchmark
All cause hospital readmissions	0.78	8.39	<=1.76
ED visits	97.12	193.26	<=172.54
Inpatient admissions	7.18	30.43	<=21.47
Mental health inpatient utilization	2.81	15.62	<=10.90
Inpatient psychiatric admissions	3.77	29.05	<=13.67

Report Period: 01/01/2017 – 12/31/2017

3. Evidence-Based Care

- Using the best available evidence to guide treatment decisions and delivery of care. Organizations need to utilize care guidelines in order to condense and summarize all available research regarding the best way to address a clinical problem (e.g., a care guideline for treat-to-target depression care).
- Embedding evidence-based guidelines in the routine provision of care through EHRs allows providers and members access to evidence needed for care decisions.
- Embedded decision flow charts for various conditions help users sort through the evidence-based treatment options and decide upon the best course of action.
- Clinical decision support using data analytics to match a single evidence-based care recommendation out of a whole guideline to an individual specific clinical situation is invaluable. Clinical decision support embedded within EHRs means that health care providers need not memorize multistep guidelines or spend their limited time looking up care guidelines.

Care Management – Putting Population Management into Action

Using Data:

- Care managers use CCT (risk scores, etc.) to select patients with high utilization of avoidable services (such as ER and hospital). After selection, members are analyzed as a population to identify their common characteristics
- Examples of common characteristics include:
 - Particular diagnoses
 - Comorbid mental health and substance use conditions
 - Chronic pain
 - Polypharmacy
- This allows for identification of member-specific actionable care gaps for members not receiving the best care for their conditions

Care Management: Care Gaps

CARE GAPS INCLUDE:

- ✓ Not having received a recommended preventive care screening
- ✓ Not having received recommended monitoring laboratories for the selected chronic conditions
- ✓ Not receiving the recommended best practice treatment for chronic conditions
- ✓ Non-adherence to medications
- ✓ Lack of periodic follow-up with primary care or behavioral health providers.

Addressing Non-Adherence

- Some members are non-adherent with treatment. How can this be addressed?
 - Providing education: Help the member to understand the conditions and the recommended treatments
 - Understanding barriers: Explore potential social determinants that may interfere with adherence. May require linking with community resources such as transportation
 - Provide prompts that may increase adherence such as electronic or telephonic



Care Management: Member Outreach

- The care manager uses the CCT to monitor and identify care gaps. Once care gaps are identified, the care manager and the integrated care team decides who will intervene regarding the identified care gap.
- The team should include **all members** of the mental health treatment team including the Health Link team.
- The nurse care manager or another delegated member of the team reaches out to the patient on a regular basis (often weekly at the start and then more infrequently as the patient begins to improve) to assess how he/she is doing, educate, and intervene in additional care gaps.
- A nurse often manages labs including education, tracking, and follow up.
- The check-ins can be brief (usually 15 to 20 minutes), and some can be conducted by phone or in person.

NOTE:

The provision of care management solely by telephone (i.e., with the care manager never having met face-to-face with the consumer), has not been found to be as effective as in-person care management

Care Management: Team Meetings

- Care management by phone contact is effective when there is already an established face-to-face personal relationship between the care manager and the member, and combining telephone and in-person check-ins can be effective.
- Care managers typically use a registry (CCT, EHR, or spreadsheet) to keep track of member panels and to make sure that they are followed up with regularly.
- The care team meets on a regular basis (usually weekly) to:
 1. Review panel of members
 2. Prioritize which have the most urgent immediate need for care or opportunity for improvement
 3. Plan which members of the team will be responsible for which interventions with which clients
- The selected care team member communicates recommendations to the treating provider (could be primary care or behavioral health provider), who then works with the patient to change the treatment plan and fix the identified care gap.

Case Management: Delegating Responsibilities

- Care management functions can be taken on by different types of providers. The training and credentials of the care managers determine the functions they can appropriately take on, with more limited services being provided by those with less training.
- When using non-credentialed staff, it is important to provide regular supervision and support from licensed team members, especially those with nursing backgrounds that can address specific medication concerns.
- Additionally, non-credentialed staff have the advantage of being lower-cost than licensed care managers. Care management teams integrating both are likely to more be effective and lower-cost than either used alone.

Historically, care management has been provided by nurses and social workers (or equivalent master's-level professionals). Social workers are trained in their professional schooling to do coordination activities, whereas nurses have been schooled in medical management and education. Mental health case managers and peer specialists are increasingly being trained in care management to augment nurses and social workers. While they may have less formal training, peer specialists and community health workers often have lived experience successfully addressing multiple chronic conditions for themselves or their loved ones and can support clients with a high degree of cultural competence.

Developing Integrated Care Plans

Member Assessment

- Should include multiple domains to get an accurate view of the strengths, needs, and barriers of members in order to create a realistic person-centered care plan.
- May require obtaining health records from other providers or making referrals for identified follow up

Mental Health

Substance Use

Physical Health

Pharmacy

Social
Determinants
of Health

Rehabilitative

Long-Term
Care

Dental

Vision

Health records are shared among providers so that services are not duplicated or neglected

- Duplication among healthcare services is a problem in multiple ways
 - Increased cost when each provider orders the same diagnostic labs or provides other duplicative services for member care
 - Increases the chance that the member may:
 - Get annoyed at duplicate requests and refuse
 - Have challenges with transportation or getting additional time off from school or work
 - Feel that the providers are not coordinating care (hint: they usually aren't)
- Obtaining member Release of Information (ROI) for care coordination:
 - Authorization to share health information with other providers
 - Request health information from other providers
 - Maintain a log for easy access to determine the ROIs on file as well as expiration dates to avoid lapses

The Care Plan*

1. Clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs
2. Clearly identifies family members and other supports; they are included in the plan as requested by the member
3. Clearly identifies goals and timeframes for improving the member's health and health care status, including interventions for achieving goals
4. Includes outreach and engagement activities that will support engaging members in care and promoting continuity of care
5. Includes periodic reassessment of the individual needs, identifying progress in meeting goals and changes in the plan based on the member's need.
 - a. Tracking tools are useful to determine timeframes for reassessments. For example, preventive screenings, EPSDTs, labs and other checks for chronic conditions (e.g., blood pressure or blood sugar checks) will all have different timeframes based on recommended guidelines.

Goals

SMART

S: I want to improve my fitness level

M: Walking 2 miles with ease

A: I will walk three days per week, increasing the distance each week by $\frac{1}{4}$ mile

R: Frequent walking is relevant to my other goals of controlling my blood pressure and reducing anxiety

T: 2 months from today

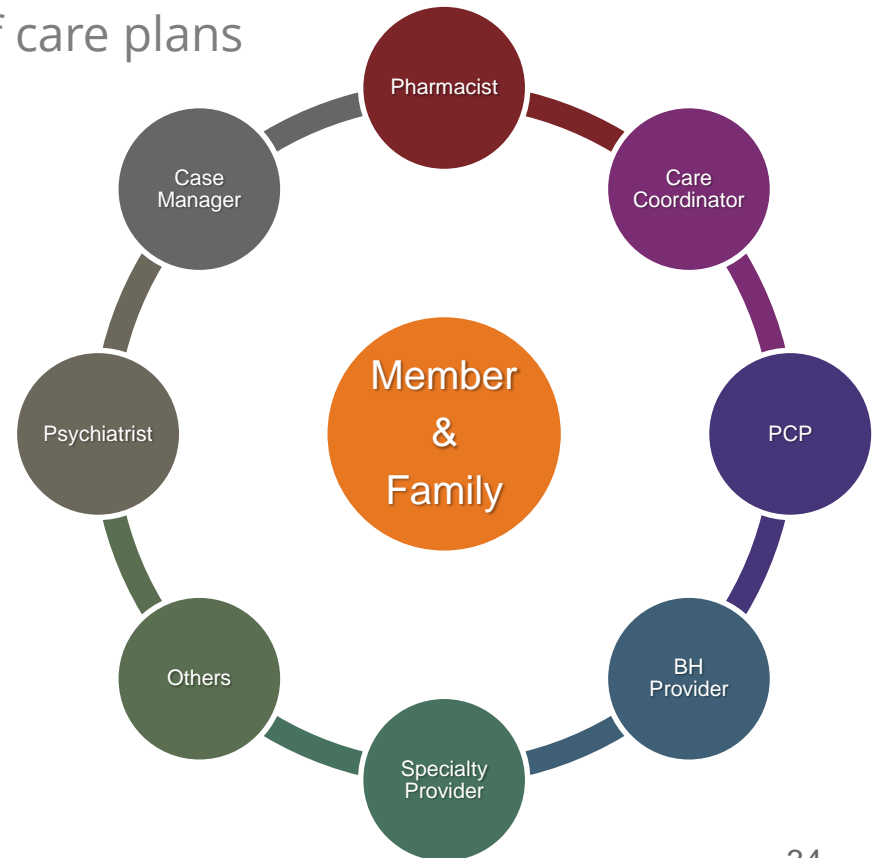
Vague

- I want to be healthier
- I will walk more often

Developing individualized, person-centered care plans for each member that address all domains

- Integrates the continuum of medical, behavioral health services, rehabilitative, long-term care and social service needs and clearly identifies each provider involved in the individual's care
- Workflow supports development of care plans that include all domains

The member and guardian, as applicable, play a central and active role in development of the plan and should agree on all goals and timeframes



Key Takeaways

The key takeaways from today's webinar include:

1. You should have an understanding of the Health Link service, Comprehensive Care Management
2. You should understand how to use Population Management for improving health outcomes for Health Link members
3. You should be able to develop an Integrated Care Plan for Health Link members

For Discussion....

- What population based management strategies are working for your team, and which do you struggle with?
- How useful are the data tools to your practice? Are you using them to their fullest extent? What do you need to use population data to its fullest extent in managing your clients and achieving better outcomes?
- What successes have you had in the Health Link program? How can you build off that success?
- What areas of your practice have been transformed by your work in the Health Link program and how have those transformations improved outcomes for your clients?
- Where can we be more helpful in supporting your work?



THANK YOU

Appendix

10 Steps to Implementing Population Management

1

Map out all the places (databases, records, etc.) your organization stores information on diagnosis, clinical values (lab results, blood pressure, etc.) and treatment

2

Aggregate all the data you collect into a single database

3

Identify which care gaps you can act on without having to gather additional data

4

Talk with your staff about the difference between population health-based care delivery and patient compliant-based care delivery

5

Focus on quick and easy interventions (such as treatment of hypertension) before long-term interventions (such as weight loss)

6

Select a care gap which is easily and rapidly treated (such as hypertension) and have a care manager generate a list of all patients with this

7

Identify a set of responses to the indicator (e.g., referral to a PCP, patient inquiry/follow-up, med adherence check) & work with treatment team to confirm response & assign a team member to take action

8

Educate staff and patients on the current care gap being pursued

9

Benchmark your progress as an organization and by teams

10

Identify additional data that can be easily collected to address other actionable care gaps

Preventive Care Services Example

Population Health Management – Preventive Care Services example

Reports:

Patient Reminders for Overdue Health Maintenance

Date Range: October 1, 2016 – December 31, 2016

This report is run quarterly, and pulls a list of all patients that are **overdue** for Health Maintenance/Preventive care services: mammogram, colonoscopy, influenza, pneumonia, diabetes foot exam, diabetes eye exam, HbA1c, diabetes urine protein, annual wellness exam.

Patient Reminders: SPH GSB Overdue HR | of Thu 1/5/2017 11:42 AM

Options: MyChart Follow-up Phone Follow-up Mail Follow-up Chat Encounter Communication PDF Workflow Add to List

PCP	MIN	Patient	DOB	Age	Sex	PCP	PI Comm Pref	Phone	PI Portal Status	Last General PI Outreach Action	Last General PI Outreach
✓ PCP							MyChart		Activated	Patient Portal Message	04/15/2015
PI Comm Pref							Phone		Not Used	Mail	06/23/2014
PI Portal Status							MyChart		Activated	Mail	04/22/2015
Last General PI Outreach Action							MyChart		Activated	Patient Portal Message	06/23/2014
Contains:							MyChart		Activated	Patient Portal Message	05/13/2014
From:							MyChart		Not Used	Mail	07/13/2014
To:							MyChart		Activated	Patient Portal Message	04/15/2015
Blanks:							MyChart		Activated		

Batch Letters are printed and mailed, and MyChart messages are sent based on Patient Communication Preference column.

Once reminders are sent, the date will appear under Last Generated Patient Outreach, indicating which method was used (patient portal vs. mailing).

Appointment Follow Up Example

Population Health Management – List of Patients needing return appointment for Chronic Condition

Call Back List for Patients Needing Follow-up for Chronic Condition

Dr. Zeius and Zira of ABC Peds use the Quality Measures reports in eClinicalWorks to proactively identify patients that are in need of certain screenings and immunizations. The office runs this list every quarter. The patients in black (below) do not have a follow-up appt and will be the target audience for our outreach efforts. They will receive a phone call requesting to set up their follow-up appointments.

3. Obesity Call Back List

Of 412 patients with obesity in their problem list, 302 or 73% did not have an encounter between 9/1/16-11/30/16. These patients will be the target of our follow up/ call back efforts

Registry

Overview Details Search

Search Type: Search in Assessments Search in Problem List

Encounter Date: 9/1/2016 - 11/30/2016

Patient ID	Name	Encounter Date
1001	John Doe	9/1/2016
1002	Jane Smith	9/1/2016
1003	John Doe	9/1/2016
1004	Jane Smith	9/1/2016
1005	John Doe	9/1/2016
1006	Jane Smith	9/1/2016
1007	John Doe	9/1/2016
1008	Jane Smith	9/1/2016
1009	John Doe	9/1/2016
1010	Jane Smith	9/1/2016
1011	John Doe	9/1/2016
1012	Jane Smith	9/1/2016
1013	John Doe	9/1/2016
1014	Jane Smith	9/1/2016
1015	John Doe	9/1/2016
1016	Jane Smith	9/1/2016
1017	John Doe	9/1/2016
1018	Jane Smith	9/1/2016
1019	John Doe	9/1/2016
1020	Jane Smith	9/1/2016
1021	John Doe	9/1/2016
1022	Jane Smith	9/1/2016
1023	John Doe	9/1/2016
1024	Jane Smith	9/1/2016
1025	John Doe	9/1/2016
1026	Jane Smith	9/1/2016
1027	John Doe	9/1/2016
1028	Jane Smith	9/1/2016
1029	John Doe	9/1/2016
1030	Jane Smith	9/1/2016
1031	John Doe	9/1/2016
1032	Jane Smith	9/1/2016
1033	John Doe	9/1/2016
1034	Jane Smith	9/1/2016
1035	John Doe	9/1/2016
1036	Jane Smith	9/1/2016
1037	John Doe	9/1/2016
1038	Jane Smith	9/1/2016
1039	John Doe	9/1/2016
1040	Jane Smith	9/1/2016
1041	John Doe	9/1/2016
1042	Jane Smith	9/1/2016
1043	John Doe	9/1/2016
1044	Jane Smith	9/1/2016
1045	John Doe	9/1/2016
1046	Jane Smith	9/1/2016
1047	John Doe	9/1/2016
1048	Jane Smith	9/1/2016
1049	John Doe	9/1/2016
1050	Jane Smith	9/1/2016
1051	John Doe	9/1/2016
1052	Jane Smith	9/1/2016
1053	John Doe	9/1/2016
1054	Jane Smith	9/1/2016
1055	John Doe	9/1/2016
1056	Jane Smith	9/1/2016
1057	John Doe	9/1/2016
1058	Jane Smith	9/1/2016
1059	John Doe	9/1/2016
1060	Jane Smith	9/1/2016
1061	John Doe	9/1/2016
1062	Jane Smith	9/1/2016
1063	John Doe	9/1/2016
1064	Jane Smith	9/1/2016
1065	John Doe	9/1/2016
1066	Jane Smith	9/1/2016
1067	John Doe	9/1/2016
1068	Jane Smith	9/1/2016
1069	John Doe	9/1/2016
1070	Jane Smith	9/1/2016
1071	John Doe	9/1/2016
1072	Jane Smith	9/1/2016
1073	John Doe	9/1/2016
1074	Jane Smith	9/1/2016
1075	John Doe	9/1/2016
1076	Jane Smith	9/1/2016
1077	John Doe	9/1/2016
1078	Jane Smith	9/1/2016
1079	John Doe	9/1/2016
1080	Jane Smith	9/1/2016
1081	John Doe	9/1/2016
1082	Jane Smith	9/1/2016
1083	John Doe	9/1/2016
1084	Jane Smith	9/1/2016
1085	John Doe	9/1/2016
1086	Jane Smith	9/1/2016
1087	John Doe	9/1/2016
1088	Jane Smith	9/1/2016
1089	John Doe	9/1/2016
1090	Jane Smith	9/1/2016
1091	John Doe	9/1/2016
1092	Jane Smith	9/1/2016
1093	John Doe	9/1/2016
1094	Jane Smith	9/1/2016
1095	John Doe	9/1/2016
1096	Jane Smith	9/1/2016
1097	John Doe	9/1/2016
1098	Jane Smith	9/1/2016
1099	John Doe	9/1/2016
1100	Jane Smith	9/1/2016

Patients who diagnosed with obesity who did NOT have an appointment at ABC Peds within the 90 day period examined

Registry

Overview Details Search

Search Type: Search in Assessments Search in Problem List

Encounter Date: 9/1/2016 - 11/30/2016

Patient ID	Name	Encounter Date
1001	John Doe	9/1/2016
1002	Jane Smith	9/1/2016
1003	John Doe	9/1/2016
1004	Jane Smith	9/1/2016
1005	John Doe	9/1/2016
1006	Jane Smith	9/1/2016
1007	John Doe	9/1/2016
1008	Jane Smith	9/1/2016
1009	John Doe	9/1/2016
1010	Jane Smith	9/1/2016
1011	John Doe	9/1/2016
1012	Jane Smith	9/1/2016
1013	John Doe	9/1/2016
1014	Jane Smith	9/1/2016
1015	John Doe	9/1/2016
1016	Jane Smith	9/1/2016
1017	John Doe	9/1/2016
1018	Jane Smith	9/1/2016
1019	John Doe	9/1/2016
1020	Jane Smith	9/1/2016
1021	John Doe	9/1/2016
1022	Jane Smith	9/1/2016
1023	John Doe	9/1/2016
1024	Jane Smith	9/1/2016
1025	John Doe	9/1/2016
1026	Jane Smith	9/1/2016
1027	John Doe	9/1/2016
1028	Jane Smith	9/1/2016
1029	John Doe	9/1/2016
1030	Jane Smith	9/1/2016
1031	John Doe	9/1/2016
1032	Jane Smith	9/1/2016
1033	John Doe	9/1/2016
1034	Jane Smith	9/1/2016
1035	John Doe	9/1/2016
1036	Jane Smith	9/1/2016
1037	John Doe	9/1/2016
1038	Jane Smith	9/1/2016
1039	John Doe	9/1/2016
1040	Jane Smith	9/1/2016
1041	John Doe	9/1/2016
1042	Jane Smith	9/1/2016
1043	John Doe	9/1/2016
1044	Jane Smith	9/1/2016
1045	John Doe	9/1/2016
1046	Jane Smith	9/1/2016
1047	John Doe	9/1/2016
1048	Jane Smith	9/1/2016
1049	John Doe	9/1/2016
1050	Jane Smith	9/1/2016
1051	John Doe	9/1/2016
1052	Jane Smith	9/1/2016
1053	John Doe	9/1/2016
1054	Jane Smith	9/1/2016
1055	John Doe	9/1/2016
1056	Jane Smith	9/1/2016
1057	John Doe	9/1/2016
1058	Jane Smith	9/1/2016
1059	John Doe	9/1/2016
1060	Jane Smith	9/1/2016
1061	John Doe	9/1/2016
1062	Jane Smith	9/1/2016
1063	John Doe	9/1/2016
1064	Jane Smith	9/1/2016
1065	John Doe	9/1/2016
1066	Jane Smith	9/1/2016
1067	John Doe	9/1/2016
1068	Jane Smith	9/1/2016
1069	John Doe	9/1/2016
1070	Jane Smith	9/1/2016
1071	John Doe	9/1/2016
1072	Jane Smith	9/1/2016
1073	John Doe	9/1/2016
1074	Jane Smith	9/1/2016
1075	John Doe	9/1/2016
1076	Jane Smith	9/1/2016
1077	John Doe	9/1/2016
1078	Jane Smith	9/1/2016
1079	John Doe	9/1/2016
1080	Jane Smith	9/1/2016
1081	John Doe	9/1/2016
1082	Jane Smith	9/1/2016
1083	John Doe	9/1/2016
1084	Jane Smith	9/1/2016
1085	John Doe	9/1/2016
1086	Jane Smith	9/1/2016
1087	John Doe	9/1/2016
1088	Jane Smith	9/1/2016
1089	John Doe	9/1/2016
1090	Jane Smith	9/1/2016
1091	John Doe	9/1/2016
1092	Jane Smith	9/1/2016
1093	John Doe	9/1/2016
1094	Jane Smith	9/1/2016
1095	John Doe	9/1/2016
1096	Jane Smith	9/1/2016
1097	John Doe	9/1/2016
1098	Jane Smith	9/1/2016
1099	John Doe	9/1/2016
1100	Jane Smith	9/1/2016

Lab Tracking Log Example

Practice Name: ABC Family Practice, PA

1010 Healthy Way, Greensboro, NC 27514

Policy Name: Test Tracking and Follow-Up

1	Practice Name:	ABC Family Practice					
2	Location:						
3	Lab Order Tracking Log 11/1/2016 - 11/7/2016						
4	Lab Company	Lab Order(s)	Bill Type	Order Date	Doctor	Patient Name	Report Due Date
5		(1) COMP METAB PANEL					
6		(2) CBC (HGB, HCT, WBC, PLT)					
7		(3) VITAMIN D, 1,25-DIHYDROXY	Insurance	11/07/2016			11/14/2016
8		(4) QUESTASSURED 25-OH VIT. D					
9		(5) HEMOGLOBIN A1C					
10	Quest (E-Order)	(6) MICROALBUMIN/RAND U (VICR)					
11		(1) COMP METAB PANEL					
12		(2) RESP ALLERGY PROF REG I					
13		(3) CHLAMYDIA/GC RNA/TMA					
14		(4) RPR VITRER + COMP RFX					
15		(5) VITAMIN D, 1,25-DIHYDROXY					
16		(6) PSA, TOTAL					
17	Quest (E-Order)	(7) TSH	Insurance	11/07/2016			11/14/2016
18		(8) URIC ACID					
19		(9) URINALYSIS COMPLETE					
20		(10) CBC (INCLUDES DIFF/PLT)					
21		(11) HEMOGLOBIN A1C					
22		(12) MICROALBUMIN/RAND U (VICR)					
23		(13) LIPID PANEL					
24		(14) FOOD ALLERGY PROF W/REFLS					
25		(1) HIV-1/HIV-2 AG/AB SCREEN W/REFLEX					
26		(2) HEMOGLOBIN A1C					
27		(3) HEPATITIS B SURFACE AG					
28		(4) HEPATITIS A AB, TOTAL					
29		(5) HEPATITIS B CORE AB TOTAL					
30		(6) HEPATITIS B SURFACE AB					
31	Enzo (E-Order)	(7) TSH	Insurance	11/07/2016			11/14/2016
32		(8) T3, FREE					
33		(9) CHLAMYDIA/GC RNA/TMA, URINE					
34		(10) THYROXINE, FREE (FT4)					
35		(11) COMPLETE BLOOD COUNT					
36		(12) URINALYSIS					
37		(13) COMPREHENSIVE METABOLIC PANEL					
38		(14) LIPID PANEL					
39		(1) COMP METAB PANEL					
40		(2) VITAMIN D, 1,25-DIHYDROXY	Insurance	11/07/2016			11/14/2016
41	Quest (E-Order)	(3) CBC (INCLUDES DIFF/PLT)					
42		(1) SED RATE (ESR)					

Effective Date: 7/15/2016

Page 3

Integrated Treatment Plan

Developing Harriet's Care Plan

Goal: "I Want To Get Back to Work"

Strengths

- ▶ Actively engaged in mental health treatment to manage her schizophrenia
- ▶ Actively willing to take medications for her diagnosis of schizophrenia with support of peers
- ▶ Has several friends that she socializes with that have diabetes
- ▶ Looking forward to having a home health care manager
- ▶ Is interested in the money she can save by not smoking
- ▶ Looks forward to returning to work

Barriers

- ▶ Overweight
- ▶ Has had multiple primary care providers
- ▶ Doesn't feel different when taking HTN medications and therefore does not get prescriptions filled regularly
- ▶ Co-workers smoke cigarettes
- ▶ Beliefs that using syringes to manage her diabetes is "unclean" and "dirty"
- ▶ Three recent hospitalizations related to HTN and diabetes

Barriers, Objectives and Interventions

Barrier	Objective	Interventions
Harriet wants to sustain smoking cessation in order to improve her health/continue to work however has co-workers that smoke.	Over the next three months, Harriet will show improved physical health as evidenced by remaining smoke free.	<ol style="list-style-type: none"> 1. CMHC therapist will provide smoking cessation group for 30 minutes, twice a week, over the next 3 months in order to problem solve barriers faced with smoking cessation at work. 2. CMHC psychiatrist will meet with Harriet once a month for 20 minutes over the next three months to prescribe and monitor impact of smoking cessation medications. 3. Frank, Harriet's co-worker, will go walking with Harriet during work breaks to help her reduce smoking in order to achieve improved health and remain working as a mechanic.
Harriet does not feel that the medications for HTN make her feel any different.	Harriet will improve management of her hypertension as evidenced by taking medications daily over the next 3 months.	<ol style="list-style-type: none"> 1. Health Home Care Manager will provide care coordination between Harriet and her primary care physician three times a month over the next three months to monitor engagement and outcomes of her physical health. 2. Home Health Nurse will visit Harriet, at her home, once a week over the next three months to provide education, monitor blood pressure and support Harriet's interest in taking medication as prescribed so she can stay out of the hospital.
Harriet has beliefs that using syringes to manage her diabetes is "unclean" and "dirty."	Harriet will challenge her beliefs related to syringes as evidenced by giving herself daily insulin injections for a period of 2 months during the next 3 months.	<ol style="list-style-type: none"> 1. Peer Support worker, who also has diabetes, will accompany Harriet to weekly diabetes management group in the community to learn about using syringes and managing diabetes. 2. Home Health Nurse will visit Harriet, at her home, once a week over the next three months to provide education, monitor diabetes, and assist Harriet in challenging her beliefs related to syringe use in order to avoid unnecessary hospitalization.

Sample Integrated Care Plan Template

Care Plan Template

Patient's Name: XXXXX **DOB:** XX / XX / XX **Code Status:** XXXXXXXX **Insurance Info:** XXXXXXXX

☐ **New Care Plan:** I have actively participated in the development of my Care Plan with my Care Manager/Team.

• I have a copy and will actively partner with my Team to follow this Care Plan.

Patient's Name: _____ Patient's Signature: _____ Date: ____/____/____

☐ **Care Plan Update/Change(s):** I have actively participated in the development of my Care Plan with my Care Manager/Team.

• I have a copy and will actively partner with my Team to follow this Care Plan.

Patient's Name: _____ Patient's Signature: _____ Date: ____/____/____

<u>Date</u>	<u>Problem(s)</u>	<u>Goals/Target Date</u>	<u>Intervention Plan</u>	<u>Responsible Party</u>	<u>Evaluation & Follow-Up</u>